Chernoff and Associates, Cosmetic Surgeons
PATIENT REGISTRATION FORM

Patient Name____ Birth Date ____________ Preferred Name___________________
First Middle Initial Last

Current Address____ ________________________ _____ _________
Street City State Zip

Cell ______________________ Other Phone _________________ Email ____

By providing my email and cell phone, I agree to receive communication from Dr. Chernoff's office via email and text messages about upcoming appointments, newsletters, and events. I also agree by providing my cell phone, I agree to receive text messages reminders for upcoming appointments.

IF PATIENT IS CHILD: ____
Parent/guardian name & address (if address is different than above)

ADDITIONAL INFORMATION

Spouse Name ______________________________________ Spouse Phone Number____

Your Employer ______________________________________Spouse Employer ____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME: ____ RELATIONSHIP: _____________________ PHONE: __________________

Address of Relative _______________________________ ____
Street City State Zip

How did you hear about us? If you do not see the source listed below, please mark "other" and let us know!

SALONS/SPAS

___ Tonya Carpenter (TC)
___ Jata Hair Salon (JHS)
___Nicole Bryan Salon (NBS)
___Conrad/ Evan Todd (ET)
___Sage Salon (SS)
___The Skin Spot Care/Julie McClain (JM)

Patient :________________________________

Employee:______________________________

OTHER

___ www.drchernoff.com website (WEB)
___ GOOGLE Search (GOOGLE)
___Real Self (RS)
___ Internet (INT)
___ Social Media (SM)
___Nicole Pence Blog (NPB)
___ www.yellowpages.com (YP)
____Silvia Love (LOVE)

MEDICAL

___ Dr. Chernoff (DRC)
___ Dr. Spurgin (DRS)

___Geist Family Practice (GFP)
___Indiana Eye Clinic (IEC)
___Dr. L. Rader (DRL)

___ Physician:________________________

Chernoff Bazaar______________Year___________

Television (TV) (list station):_____________________

Newspaper (NW) (list Newspaper):_______________

Radio____________________________________

Other____________________________________

___ Friend: ____________________
___ Indy Metro Woman (IMW)
___Sophisticated Living Magazine (SLM)
___ Columbia Club (CC) Year_______

___Seminar (S) Date_________________
___LA Fitness (LA)

___Life Time Fitness (LTF)
___Lilly Employee (LE)
___Massage Envy (ME)

All packages are to be paid in full at the time of purchase. All Services are NON-REFUNDABLE. Pre-Payment for Laser, Fillers, Botox and Surgical deposits are NON-REFUNDABLE.

To ensure patient financial confidentiality, please discuss *all* financial arrangements with the patient coordinator. I understand that I am personally responsible for all charges. I understand that the charges I am responsible for are to be paid in full at the time of service. Should collection proceedings become necessary, I understand that I will be responsible for reasonable attorney fees, court cost and all collection cost.

Signature____ Date_____________________________

Photo & Video Release Form

I grant permission to Chernoff Cosmetic Surgeons to use my video, interview, and photo for the following purposes: conference presentations, educational presentations or courses, informational presentations, on-line (website), television, newspaper, social media, and patient education.

There is no time limit on the validity of this validity of this release nor is there any geographic limitation on where these materials may be distributed. I waive any right to royalties or compensation for the use of my image or recording.

By signing this form I acknowledge that I have completely read and fully understand the above release. I release any and all claims against Chernoff Cosmetic Surgeons for using the material.

Full Name____
Address____
City____
Zip Code____
Email Address____
Signature_____________________________ Date________________

If this release is obtained from a presenter under the age of 18, then the signature of that presenter's parent or legal guardian is also required.
Parent's Signature_____________________________ Date_________________
Parent's Printed Name________________________________

I wish only for my picture to be used for chart purposes only.

__________________________________ __________________________________
Name Date

IMPORTANT: If you would like to change your permission status for photo consent, please 1) send an email to info@drchernoff.com with your name and request to change your photo status; and 2) send a letter by mail to 9002 N Meridian Street, Suite 205 Indianapolis, IN 46260 with your request. I have read the policy on photo consent:

____
Patient Initials

CHERNOFF
COSMETIC SURGEONS

PATIENT MEDICAL HISTORY

NAME: ____ DATE: ___________________

Reason for today's visit:
____
____

DOB: _______-________-_______ Ht:_____ft ______in Wt:_________lbs Gender_______________

ALLERGIES
____
____
____
Latex Yes_______No________
Bee Stings Yes______No_______

SOCIAL HISTOY:
Married ___ Single ___ Divorced ___
Widowed ___ How Many Children? _______

Family History:
Breast Cancer ___Yes ___No
Keloids ___Yes ___No
Bleeding or Genetic Disease ___Yes ___No
Do you have a history of Adverse Reactions with anesthesia? ___Yes ___No

Medications/Supplements:
____
____
____

Family Physician: ____________________________ Phone Number: ______________________________

Previous Surgeries:
____
____
____

Past Medical History:

Description	Yes	No	Description	Yes	No
Dentures	[ ]	[ ]	Tuberculosis	[ ]	[ ]
Contact Lenses	[ ]	[ ]	Neurological Disease	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	Heart Disease	[ ]	[ ]
Seizures	[ ]	[ ]	Liver Disease	[ ]	[ ]
Diabetes	[ ]	[ ]	Lung Disease	[ ]	[ ]
Pacer/Defibrillator in use	[ ]	[ ]	Kidney Disease	[ ]	[ ]
Smoker?	[ ]	[ ]	Intestinal Disorder	[ ]	[ ]
Packs per day? ___________			Thyroid Disease	[ ]	[ ]
Other: ___________________________			HIV +	[ ]	[ ]
			Hepatitis	[ ]	[ ]

Reviewed health and history with patient ___________________________________ _______________
DOCTOR SIGNATURE DATE

CHERNOFF
COSMETIC SURGEONS

NO SHOW & CANCELLATION POLICY
We are often on a waiting list for appointments. In order to allow patients on our waiting list appointments, we kindly ask that you give **2 business days** (M-F) if canceling or changing an appointment. In the event of less than 2 business days or a "no show," there will be a charge of $85.00 posted to your account.

COSMETIC PROCEDURES: All cosmetic procedures must be paid in full at the time of service. Surgical procedures must be paid in full before any procedure is performed.

POLICY ON PACKAGE PURCHASES: All packages purchased are to be paid in full at the time of purchase. Packages are non-refundable. Packages are non-transferable.

SKIN CARE PRODUCT PURCHASES: All returned unopened product boxes will be credited to your account and may be used toward any services if returned within 30 days of purchase. All opened product sales are final and cannot be refunded.

RETURNED CHECKS: There will be a charge in the amount of $30.00 for any returned check. This policy is strictly enforced, and future treatments MAY be withheld until NSF checks have cleared the bank.

FINANCIAL ARRANGEMENTS: Our commitment of excellence through our various services is extended to you with regard to the payment of our services. In order to achieve this goal, definite payment arrangements must be established by your second visit. All charges quoted pertain only to Dr. Chernoff's charges additional charges will also be charged to you from outside sources with all surgery cases.

ALL REFUNDS WILL BE PROCESSED WITHIN 120 DAYS OF APPROVAL.

WAITING ROOM: We strive to provide the best treatment in a relaxing environment, so please make child care arrangements in advance and mute all cell phones.

PRIVATE INSURANCE COVERAGE: You are responsible for the full amount of our charges. You may keep your receipt and file directly with your insurance.

NO INSURANCE: Payment in full is expected at each visit. Should you require prolonged treatment; a monthly payment arrangement can be established. At the conclusion of your treatment, all services are to be paid in full within 60 days.

WORKER'S COMPENSATION: A confirmation, by phone or other means, is required to acknowledge the services as Worker's Compensation. If by letter, that letter should include a claim mailing address and the contact person at your place of employment.

ACCIDENT CASES: Accident cases are considered self-pay and we do not become involved in litigation of the settlement of these cases except where required by Federal law (Medicare/Medicaid). You will be given a receipt for any payment made to pursue your claim in these situations.

NO CHALLENGE POLICY: Services that are performed and are paid with a credit card, or financing third party are not eligible for payment challenges after services are provided. I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I agree that this non-credit card challenge agreement is irrevocable.

By signing below, I certify that I have read and understand the above stated information. I understand, once again, that I am responsible for any amount not covered by insurance. I will also be responsible and liable for all collection of attorney fees incurred while enforcing collection of said amount.

____
Printed Name

____ ____________________
Signed (Patient or responsible party) Date

ACKNOWLEDGMENT OF HIPAA PRIVACY PRACTICES

ON OCCASION A FAMILY MEMBER, FRIEND OR CAREGIVER MAY CONTACT CHERNOFF AND ASSOCIATES TO INQUIRE ABOUT YOUR MEDICAL INFORMATION. PLEASE LIST THOSE INDIVIDUALS TO WHOM THE INFORMATION MAY BE DISCLOSED:

NAME(S)	RELATIONSHIP
______________________________	______________________
______________________________	______________________
______________________________	______________________

I hereby acknowledge that I have received a copy of Chernoff and Associates, Cosmetic Surgeons Notice of Privacy Practices.

Signature: ____

Printed Name: ____

Date: ____

IMPORTANT

If you are completing our new patient paperwork at home, you will be provided a copy of our privacy practices when you come to the office and you can sign this form at that time.